UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
CHARLOTTESVILLE DIVISION

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CYNTHIA B. SCOTT, et al.,

Plaintiffs,

vs.

HAROLD W. CLARKE, et al.

Defendants.

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CIVIL ACTION 3:12-CV-00036
MARCH 8, 2021 10:00 A.M.
MOTIONS HEARING VIA ZOOM

Before:
HONORABLE NORMAN K. MOON
UNITED STATES DISTRICT JUDGE
WESTERN DISTRICT OF VIRGINIA

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Proceedings recorded by mechanical stenography. Transcript produced by computer.

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(Proceedings commenced, 10:00 a.m.)

THE COURT: Heidi, you may call the case, please.

CLERK: Yes, Your Honor.

This is Civil Action Number 3:12-cv-36, Cynthia B. Scott and others versus Harold W. Clarke and others.

THE COURT: Plaintiffs ready?

MR. HOWARD: We are, Your Honor.

THE COURT: Defendants ready?

MR. SCHNETZLER: Yes, Your Honor.

THE COURT: Okay. I'll remind any members of the public that under Standing Order 2020-12, the Court's prohibition against recording and broadcasting court proceedings remains in force. Attorneys, staff, and members of the public accessing this hearing today may not record or broadcast it.

We are here today on a regularly-scheduled status conference to assess the state of FCCW's compliance with the terms of the settlement agreement. I thank the parties for their submissions in advance of this hearing, which I -- and I have reviewed those submissions.

Before we begin, I'll just make a few preliminary remarks. First, as the parties' filings reflect, the case is in some respects in a transitional period. The court appointed Dr. Homer Venters as the new compliance monitor after Dr. Scharff's resignation as monitor. I understand that

Dr. Venters has already requested documents and intends to visit FCCW this month, and that should be interesting.

Second, this transitional period should serve as a stark reminder about the length of time there has not been complete compliance. The settlement agreement was approved in 2016. We are now over five years after settlement, and all the parties should take the opportunity and redouble their efforts to quickly and sustainably hit the benchmarks.

Pursuant to the court's briefing schedule, the parties have filed their briefs. I think I'll hear from the plaintiffs first.

MR. HOWARD: Yes. Good morning, Your Honor. Ted Howard for the plaintiffs.

Your Honor, with regard to the defendants' status report filed on February 8th, there really are sort of three main points that I think the plaintiffs would like to emphasize at this point. The first is that despite the fact that it was filed on February 8th and does address COVID-19 outbreak issues that were -- that arose in November and December of 2020, there was a significant additional outbreak in January carrying over into February that is not addressed at all in the defendants' status report. It's a little concerning and a little perplexing as to why that would be the case.

As of February 8th, the date on which the defendants' status report was filed, VDOC's online reporting with regard to

COVID-19 indicated that there were 144 active cases at Fluvanna, including one hospitalization. Now, certainly as of today, it appears that that number has come down quite a bit, which is, you know, something we're all grateful for. But the failure of the defendants to address the major outbreak in January and February is concerning. That's particularly so because --

THE COURT: You mean to address it in the report, not to address it --

MR. HOWARD: I mean in the report, yes, Your Honor.

THE COURT: Okay.

MR. HOWARD: It's particularly concerning to us, among other reasons, because as regards the November and December outbreaks that were addressed in the report, it appears that the source of the infection, the originating infection that caused the outbreak, was with staff in three of the four instances, and a prisoner transferring in from another facility in the fourth instance. And the report does not seem to address in any way what measures Fluvanna has adopted or is implementing to try to, you know, prevent those sources of infection from having an adverse impact on the prisoner population. And we have no information about what the sources were of the infections that caused the January outbreak.

We also have some significant concerns, which we have outlined at pages 4 through 8 of our report filed on

February 22nd, about what we've heard from our clients, and indications that as regards the quarantining practices being utilized at the prison, that they don't seem to have been effective in preventing further spread, and they don't seem in some instances to actually even align with the published written protocols and guidelines that VDOC has made available. That concerns women being transferred to so-called yellow zones where they don't appear to have been exposed or infected when they got there, but it appears that they were infected while in the yellow zone as a result of commingling with others who were reporting signs and symptoms of infection. And as regards the red zones, where women with confirmed positives have been transferred, there are significant concerns with regard to the fact that there aren't call buttons in those cells. Women have to undertake extraordinary measures to actually get someone's attention if they need medical care, etc. So there are still some very significant concerns that the plaintiffs have with regard to COVID-19 issues.

We would also note that although Dr. Venters has been in touch with the prison requesting specific documentation with regard to certain practices and procedures that they utilize with regard to COVID-19, and certain data with regard to results, to the extent that he has been provided with those documents, they were not provided to the plaintiffs.

The second point I'd like to just touch on briefly,

Your Honor, is that pages 3 through 10 of the defendants' status report of February 8th catalogs a whole laundry list of representation -- or contains a whole laundry list of representations with regard to measures that are said to have been undertaken in order to address issues of noncompliance or partial compliance as of the time that Dr. Scharff issued his last report before he withdrew. The concern there is just that it's just a string of representations. There are no citations to documents, and no documents have been provided to support those representations. So we're left with essentially having to take defendants' word for the fact that those measures were actually undertaken.

And lastly, the continuing problem is that there is just no measuring mechanism by which to evaluate what the defendants say that they have done and are doing. This is a critical point that we emphasized in connection with our concerns about Dr. Scharff, that he had failed to articulate clear metrics by which actual progress towards compliance could be evaluated, and/or we could actually make a judgment when he said that they were either in compliance or partially compliant as to what that actually meant. And it really underscores how critical it will be, hopefully as soon as practicable, for Dr. Venters to establish those metrics by which we can actually evaluate where things stand, what progress is being made, and how far we still have to go.

So those are the -- those are the major points that I wanted to address, Your Honor. If you have any questions, I'd be happy to try to take them on.

THE COURT: Okay. Are you saying that you're getting less information today than you were --

MR. HOWARD: No, Your Honor.

THE COURT: -- months ago?

MR. HOWARD: I think it's fair to say that our complaint has always been -- or at least has fairly consistently been -- that, you know, our principal, and in many instances only, source of information with regard to what's actually happening at the prison with respect to medical care on any given day is through the reports that we get from our clients, not as a result of documentation that we get that actually supports the information or the representations made by the defendants in their -- in their papers.

THE COURT: Okay. Do you anticipate that you're going to -- there will be problems with your clients taking the vaccine?

MR. HOWARD: Your Honor, it's a little difficult to say, because I think, as we pointed out in our report, the information available to our clients to assure them or to reassure them as to the efficacy of the vaccine, you know, its availability, what possible impact it may have on them, they at least tell us that that information has been hard to come by.

THE COURT: Okay. All right. We'll hear from the defendants.

MR. SCHNETZLER: Good morning, Your Honor. Nathan Schnetzler for the defendants.

Your Honor, I'd like to actually jump straight to the issue you just raised with plaintiffs' counsel, because there seems to be a significant gap of information between class counsel and class. As of late last week, over -- or excuse me, 77 percent of the inmates at FCCW have received their first shot. So I would just disagree with the representation that the plaintiffs are expressing, you know, lack of understanding or concern about receiving the vaccine. It's actually much higher than the community rate. And so we're doing very, very well with educating there about the importance of the vaccine.

THE COURT: Does plaintiffs' counsel get that information from you, from the defendant, so that they would know the percentage that are getting the vaccine?

MR. SCHNETZLER: They have not asked us.

THE COURT: Excuse me?

MR. SCHNETZLER: They have not asked us, Your Honor. And I don't know where -- what we're -- what system is supposed to be set up that we're supposed to be providing --

THE COURT: When did you start administering the vaccine?

MR. SCHNETZLER: I'd have to defer to Dr. Targonski

on when administration started, if that's all right.

THE COURT: Okay. All right. Go ahead.

Well, I'm just saying one of the things -- they raised this issue in their pleadings, and it looks like the information could have been given to them before today just to head off the discussion.

MR. SCHNETZLER: Your Honor, if they had asked us -- they have not been hesitant to ask us questions about individual women, about individual concerns.

THE COURT: Okay. But -- all right. It would just -- when you do something really good, I think you ought to advertise it.

MR. SCHNETZLER: Sure, Your Honor. We'll make a point of that going forward. Well taken.

Your Honor, with respect to the plaintiffs' concerns about the documents that Dr. Venters requested and that is not being provided to plaintiffs, that's incorrect as well. Dr. Venters has requested the quarterly reports that the facility has done, the mortality reviews, and VDOC's COVID response documents. All those have been provided to plaintiffs' counsel. So I don't know where the representation is coming from that we're not providing that information to opposing counsel. I'm providing, I think almost on a weekly basis, updates to VDOC's statewide manual to plaintiffs' counsel and how VDOC is responding to the pandemic. And again,

you know, the documents Dr. Venters requested, I have not received any follow-up request for any other additional information from Dr. Venters. All that has either been contemporaneously or previously provided to plaintiffs' counsel.

And then, Your Honor, with respect to the issues that the defendants focused on in our status report, which of course is the purpose of these hearings, and Dr. Scharff did not find that the defendants were noncompliant in any of the areas the settlement agreement covers. He addressed about a half dozen areas of partial compliance. We addressed those. And I understand that plaintiffs' counsel don't know where the information is coming from with respect to what the defendants are doing to continue to improve the practices at FCCW, but all that information is in the most recent quarterly report we provided them. So again, I'm just at a loss as to why those representations, as they have been called by opposing counsel, don't seem to have any backup when we provided a significant document to opposing counsel prior to filing our status report that outlined those measures that the defendants have been conducting with respect to the areas of partial compliance.

So Your Honor -- and with respect to the response to the COVID outbreak, our report did go through the January outbreak. I noted that the last outbreak we discussed was one that completed isolation January 18, 2021. Those -- there was

another outbreak, Your Honor -- and it was not listed in there -- that went into February. That is correct. Again, we were working on this right there the beginning of February. Did not have all the data yet for that outbreak. I am happy to report, though, that testing from the women in the yellow zone -- which is where they're quarantined -- this morning found that there were no positive cases in the quarantine at FCCW.

And then finally, Your Honor, the last thing I wanted to just address is there have been a number of issues raised with respect to the defendants' response to the COVID outbreaks. One issue we need to point out is that part of perhaps maybe the misunderstanding from plaintiffs' counsel is that they are demonstrating sort of a lack of understanding of how the VDOC's response measures actually are put into place. They're incorrectly using quarantine and isolation interchangeably throughout their status report, which those are two separate concepts that should not be used interchangeably. FCCW is using a program or response plan that has a yellow zone, which is for quarantine, and then a red zone, which is for positive cases that is considered an isolation area. And the plaintiffs continually confuse those two concepts throughout their status report, and it can obviously raise -- if you're using the wrong terms, it's mixing up separate responses.

THE COURT: So when someone goes into quarantine, is there a specific time that they stay there? Is it 14 days?

MR. SCHNETZLER: There is a time, but there is also -- FCCW has actually implemented a procedure where the women must test out of quarantine. So there is isolation, which is 14 days, and then they have to test out of quarantine. So they must have a negative test in order to be taken out of quarantine. And if I misstated something, I'll ask Dr. Targonski to correct me. And I think I may have misspoken. So I may have to have him correct me.

THE COURT: Well, I'm not suggesting that. But I've had this come up in some cases with prisoners in other places, not necessarily the state, that they go into quarantine, and then someone else comes into quarantine when they're about to get out, and then they have had to extend their stay in quarantine. I'm not suggesting that's what's going on with the defendant here. But it seems like you could almost be there forever, and eventually you would get the disease because somebody would come into quarantine who was infected.

MR. SCHNETZLER: Right. I would rather, if I could, have Dr. Targonski speak to that so that I don't make a misstatement on that process.

THE COURT: All right.

MR. SCHNETZLER: So with that, Your Honor, the defendants are anxious for Dr. Venters to begin his first

visit -- I believe it's set up for next week -- and anxious to, as the court has noted, to get this case moving out of the transition period, and to a point where we can see a light at the end of the tunnel, so to speak, with respect to having this case drawn to a close.

THE COURT: All right. I have some questions. Are you going to have Dr. Targonski speak?

MR. SCHNETZLER: Yes, Your Honor. If now is appropriate, I'd like to have him address a couple of those issues that you raised, if the Court would prefer.

THE COURT: Okay.

DR. TARGONSKI: So Judge, please tell me if you have something specifically you want me to speak to.

I'll start with this idea of quarantine and isolation. Yellow zones are the areas that are used for quarantine. Quarantine is where you take people who may have been exposed or have been exposed, are asymptomatic and not showing evidence of disease, for them to be away from others who have not been exposed in order to reduce transmission of the virus, and watch them more closely to determine if they do develop symptoms. Isolation is the separation of individuals who actually have disease, who are symptomatic who meet criteria clinically as a case, or who have tested positive. And they are separated away from others who have not been exposed, or may have been exposed, in order to prevent them

from clearly spreading the disease further within a population.

What happens in a community, frankly, is substantially easier than what happens in congregate settings, as we have all seen with nursing facilities and correctional facilities throughout the country. Our process for managing quarantine and isolation is completely consistent with the CDC guidances for correctional settings based upon our environmental structures, and has been endorsed by the Virginia Department of Health throughout. They have never suggested that we need to do anything differently, or frankly, have been able to get ahead of us on suggesting things differently.

I think the biggest challenge is that, as Mr. Schnetzler mentioned, there seems to be a confusion in the plaintiffs' status report regarding how well they understand quarantine and isolation, that they're not the same. They're not interchangeable. There's a couple of pages, I think, where we saw that -- pages 6, 7, and 8 -- and that yellow zones are actually quarantine.

So in quarantine we actually have used three different strata for quarantine. There is one quarantine where people may have been exposed to possible cases. That's the lowest level of quarantine. When people go out into the community, there is a risk that when they go to outside appointments -- they're going to a hospital, a doctor's office/hospital in particular -- there's a pretty high

likelihood, relatively speaking, that they could be exposed to a case compared to frankly staying in the facility when there's no cases in the facility, no cases in their wing.

The second level is when someone actually -- when a case has developed within a particular wing. Because people move freely throughout their wing, we are not able to tell if they may or may not have had a sufficient contact, and so we end up quarantining the wing. This is also consistent with what the CDC recommends.

And then finally we have kind of the highest level of quarantine, and that's roommates. We find that when someone has developed as a case, their roommate has a higher probability of turning into a case. They have an attack rate, a subsequent attack rate, or the proportion of roommates, for instance, who go on to develop disease after exposure is higher than for people that are just in the wing, is higher than for people that go out for outside appointments, is higher than for people who are residents of the facility but haven't been exposed at all.

So that constant replenishment of quarantine that is being suggested actually does not occur with us. What occurs is that if you're in a quarantine area and a subsequent case develops, then the clock has to reset for the people in that quarantine because a case has developed. It's not that people with infection are being brought into those areas. It's that

cases develop within those areas, and we have to -- we have to be cautious about how we view the potential risk, then, for those individuals. So we have had some ladies absolutely who have been in quarantine because cases have continued to develop over time.

I think in December the plaintiffs' attorneys actually recommended that we should be shortening quarantine, and we thought that was a terrible idea. It was not something that we felt the literature supported. We did not do it. And the CDC subsequently came out and agreed with us, in correctional settings, that it was not a good idea to do that.

We also have increased the frequency of testing that we do, because we found that some people don't recognize they have symptoms, or some people don't want to report symptoms. So we have increased the frequency of testing to improve the ability to identify cases as early as possible. The CDC has also subsequently recommended that in correctional settings. It was something that the FDA was suggesting, frankly, back in the fall as it related to long-term care facilities. So we have been kind of pushing the limits of technology to do that.

We also have been aggressively using antigen tests because we get the results immediately. The plaintiffs' attorneys had raised concerns and suggested we should be using RT-PCR, the genetic tests. But they didn't take into account that the genetic tests, unfortunately, with the volume of

testing that's increased in the community, can take up to five days before results can be returned. And you can imagine if we do a test on someone and wait five days to see if they're positive, we are really at risk of spreading illness throughout those populations. So increased our frequency of testing and our use of point-of-care testing.

We have done all of the comparative studies. I don't know that other correctional settings have done this, but we did the comparative studies between the commercial genetic tests and the tests that we're using in-house to make sure we can understand reliability, take that very seriously. And we understand the reliability of those tests and how to interpret them. And we talked about that in the most recent quarterly report as well, because it's an important message to share with other correctional settings, and, frankly, with the community. University of Virginia has appreciated when we've shared that with them to help them understand, and we've had discussions with other correctional settings as well.

So I think that -- I think that what I'm reading is really more confusion on the concepts than some type of subterfuge or withholding of information, frankly, on the part of FCCW. And, you know, everything we're doing has been in line with, if not ahead of, frankly, the CDC and VDH. You'll recall we innovated on masks. We innovated on extending screening criteria, the front entry screening. We started

testing out of quarantine back in September before CDC was suggesting that. I've already mentioned the other things that we do, our vital sign checks. We have expanded that. And we do more than the CDC, frankly, asks for. We have developed exercise programs for the ladies in quarantine so they're not getting sarcopenia, muscle loss, kind of wasting away, getting sicker if they have to be in quarantine. We've developed post-COVID care. They call it long-haulers, people who have symptoms after the acute COVID episode. It's really called post-acute sequelae of COVID. We've worked with physical therapy on our patients before they even come out of isolation to be assisting them with physical therapy, and moves to the infirmary for the ladies who may have had a little bit more challenge in order prevent them from having longer-term sequelae of COVID.

When you look at -- you know, when you look at what we're doing, if we had been doing a bad job at this, we would have had bad outcomes. Now, I know Ms. Ellis had said she thought it would be a miracle if nobody died from COVID. Thank goodness -- and I agree with Mr. Howard -- we're all very grateful we have not had a patient die of COVID. And frankly, if you look at our hospitalization rates even, if you look at hospitalization rates at FCCW from December through now, which includes that outbreak in December and January and an outbreak that -- the reason I didn't put the outbreak in January in the

quarterly report was because the quarterly report goes through December 31st. I have no problem sharing information if people ask. But if an assumption is made that the quarterly report dates are going to change -- we said what the quarterly report dates are, and I'm trying to stick to something that our staff understands as well, because they're also stakeholders expected to read and understand these quarterly reports. The outbreak that started in January, if you combine the two, about 495 cases total. Definitely a large amount of COVID. But if you actually look at the epidemic curves for our community -- and the Kaiser Family Foundation and other organizations have identified that the biggest factors influencing the development of COVID in congregate settings is, of course, what's happening in the community. I absolutely agree with Mr. Howard; it doesn't spontaneously generate like flies from raw meat, COVID. It's imported. We had reception cases imported. We actually had one lady who went for an outside appointment and acquired COVID there, unfortunately, despite that it ought to be low risk. And then, of course, if it has come in, it's either staff have brought it in or there's contamination. And we work really hard to minimize contamination with things being brought into the facility.

Nonetheless, our hospitalization rates are less than 1 percent. And if you look at the hospitalization rates around the United States just for the average age group that we have

here, 18 to 49 year-olds, our hospitalization rates, frankly, are anywhere between three and five times lower than what's being seen around the country for COVID cases. So the work that we're doing here to keep people healthy while they're having COVID is working. We're not having to send people, thankfully, to the hospital. And it's not because we're keeping them here and abusing them. It's because we're aggressively working to prevent them from having the symptoms that would require them to have to be hospitalized.

Most of what we've seen the last two -- you know, the last two months has been different than September where it was a lot of GI stuff. Most of what we're seeing has been upper respiratory, runny noses, sore throats, congestion. We've had a number of ladies that were at risk of dehydration, and we've been trying to manage them aggressively, because we found that that's one of the greatest risks for people getting ill. The cases that went -- unfortunately, every single lady that ended up having to go to the hospital had asthma or COPD. Not completely unexpected. And so there's still things we're learning. And we're trying to share that not just across the DOC, but nationally as well, so other people can keep their antenna up and manage things the right way.

I hope that answers that for you.

THE COURT: Okay. Are you getting any resistance from the inmates to the vaccine?

DR. TARGONSKI: Actually, that's a great question. A tremendous amount of resistance early on, and the -- oh, so let me tell you -- I actually think this is a good thing -- we received our first doses of vaccine for distribution in Phase 1A, which was to healthcare providers and kind of a certain subset of severe illness patients on January 6, if I'm not mistaken. And I have to admit I was kind of hacked off about that. I actually thought a much better strategy would have been, frankly, to give it to the patients in correctional settings and congregate settings, if our goal was to prevent transmission, versus keep people in positions to reduce mortality solely.

Now, I had the chance to meet with the Secretary of Public Safety Moran in December, as well as representatives of VDH, Lilian Peake, who I have worked with previously here in the health district. And I want to say that I think they actually did a really good job advocating for patients in correctional settings, because I presented evidence and a philosophy around why we needed to vaccinate patients in correctional settings. And Secretary Moran I believe worked really hard. The initial plans were for the patients in correctional settings to be Phase 3, which means they still wouldn't even be eligible, but he got them moved up to Phase 1B, I believe -- of course, along with other people too. So that gave us the opportunity to start to vaccinate a little

bit -- obviously a lot earlier. So we were vaccinating roughly by the middle to last third of January. And when we look at the epidemic curve, the outbreak in January, you can actually see that there has been an impact of the vaccine in helping drop that curve fast towards the end, and get us to where we are today with no cases of COVID and no patients in quarantine for COVID.

So the resistance that we saw to the vaccine early was the same as we see in the general population. It is: Don't trust the government, afraid of side effects, and the vaccine is too new. People don't trust it. So we did -- the DOC had its own kind of advertising campaign on this, information education campaign. And then I did videos, and we did face to face with people, and answered questions in the yellow zones. Red zones, unfortunately, it was too late. I was really discouraged by that; we couldn't have prevented more cases. But what we saw over time was that resistance waned substantially. And so I think, you know, we've been accused of not providing education. And the reality is our ladies were sophisticated enough to be discouraged by the emergency use authorization not accurately representing the true process that the FDA goes through for a slower and more detailed look at vaccines. So they're sophisticated enough to have picked up this information; and, in fact, the advertising on COVID vaccine that LAJC was doing where they're asking, if people

have questions, to go to LAJC to get their questions answered has mistakes in some of these areas about emergency use authorization process and other things. And our ladies picked that up. So they questioned us a lot.

And what we've got right now is 77 percent of our population who are eligible have received the vaccine. That is substantially higher than the general population. It is embarrassingly higher than healthcare workers in the United States. And I think it speaks to the attention that the ladies expect to this issue, as well as their willingness to listen to us.

The, you know, reports for decades -- and I have published on this -- the provider endorsement to vaccination is the single greatest factor that influences vaccine receipt. And we have endorsed the vaccine here. And I'm not going to say all of the ladies trust us, because they don't, but the ladies -- many of the ladies -- most of the ladies, I believe, do trust us and trust our intentions with this, and they've received the vaccine. And it's contributed to the reductions that we're seeing now. They're getting good education. They're questioning us about the right things. They are allowed to question us. They have access to us.

I was in one of the quarantine wings about a week ago, and the ladies were giving me all kinds of ideas of how we should change the vaccination strategy and how we should change

the quarantine strategies. And I welcome that feedback because they're seeing things different than I am. So it helps us -- it helps us to do things -- do things better.

So we are -- we are -- in fact, I think we -- the plaintiffs' attorneys mentioned that people don't have access to the providers to answer questions, and mentioned they don't have access to treating specialists. And I can tell you that's not true. One of the primary plaintiffs, I guess, in the case actually went and saw her rheumatologist and misinterpreted what the rheumatologist had said about the vaccine, and refused it. And when I saw that she had refused it, I reached out to her rheumatologist honestly to kind of yell at him first, because I thought he told her not to get it, but in fact he was endorsing it. And so I went back to her and I said, You misunderstood your rheumatologist. Here is what we know about your condition. Here is what we know about the medications you take. Here is what we know about the vaccine. I went over the data on people with autoimmune diseases in the clinical trials from Moderna and Pfizer, about 75,000 patients. I reviewed all of that with her. I reviewed with her what her provider had said. We went through his notes again. I showed her his email to me to corroborate that we had talked, and he agreed. And she got the vaccine. And I think it was the right thing to do.

So people do have access to their treating specialists. They do have access to their providers. I'm sure

Mr. Howard and Ms. Ellis and their team hear people that say it doesn't happen. And I will never lie to you; I cannot promise that everybody has access the way they want to have access. And I'm sure there are people who will always be unhappy, but really we're doing -- we're doing a very good job here.

And all of our metrics around COVID, frankly, are saying that if we're constitutionally inadequate in our care, then our country is constitutionally inadequate. And there is some people who actually might agree with that, frankly. I don't think we're doing a good enough job for everyone in the country, but we are doing a good job here. I think many of the ladies are trying very hard here.

THE COURT: Do you have enough vaccine for those who will take it?

DR. TARGONSKI: Yeah. We actually have -- the reality is we actually have more than enough vaccine, and we are a distribution hub for some of the other facilities. And one of the ethical challenges I have always been concerned about is as a vaccine hub, you know, I don't want to be put in the position where I have to feel like I'm being selfish and hoarding vaccine here, and then someone else is not getting it. But the reality is that we have more than enough vaccine to distribute not only to all of our patients, but all of our staff, and in addition still be a hub so that the other sites that work with us have enough vaccine to get to all of their

patients and all of their staff.

And in addition to that, we have created a network where we can share vaccine across regions. So we had people from southwest Virginia last week that had six extra doses left in a vial that they couldn't use. So we drove and met them halfway to go get the vial and bring it back here so we could use the vaccine here, even though we had enough, because we don't want it to go to waste. If you don't use it within six hours, it's considered no good anymore. We don't want to waste vaccine. So we're even doing those kinds of things to make sure that we're utilizing all of the vaccine as responsibly as possible.

I talked to the director of the health district and indicated that if she had extra vaccine, she should let us know and we would find ways to use it, if she was afraid she was going to lose it. We've even talked about doing that for them. If we end up in a weird spot and feel like we've got a couple of doses we don't want to go to waste, we're finding partners to be able to share that with as well. And the DOC has told us it's okay to explore that. Everybody wants to be responsible with this vaccine. It's too important for the community.

THE COURT: One of the things that's come up I noticed a number of times is that in one of the -- is it maybe the red zone, that the ladies do not have a push button for call, but have to beat on the bars to attract attention.

DR. TARGONSKI: Yeah, I can let the warden talk about call buttons, but I can tell you I have frankly never gone into the red zone when all of the doors to the rooms were closed. Most of the time that I go into the red zone, all of the doors to the rooms are open. And they're open, and it's requested that the ladies adhere with the protocols, which is not to be out walking around and going to multiple places more than, you know, a person being out for shower, a person being out for phone, a person being out for nursing, or whatever. But it's been rare that I've gone in there and everything is all locked up. If everything is all locked up, frankly, it's been when there's been a request by security to pause, because there has been too much activity and people aren't adhering with the protocols, and everybody kind of goes and does a reset.

But, you know, we put our -- frankly, we put our best nurses in there, and I've made it very clear to our director of nursing what I expect from our nurses in the red zone, and how they're going to treat patients. And my expectation is that the nurses are aware of the patients. And they have been. I think some of the things that you're hearing -- the reports that I get at the time that an event occurs are not consistent with the reports that were written into the documents that were shared, frankly. Everybody always has a different perspective on what does and doesn't happen. But, you know, we have nurses checking vital signs every four hours while the patients are

awake. I have told them not to be punitive to the patients. Don't wake people up at 2 a.m. to check vital signs, but they're expected to check on the patients and make sure that they're okay. We've expanded the vital signs because of what we've seen clinically happening. So we do more than the CDC or DOC asks at our facility. We think it's the right thing to do.

And could there have been a time when somebody's door was closed and they were banging on the door? Absolutely. I mean, whenever there is a door closed, if it were me I might bang on it too, frankly, because you're closed in. But I have not seen a single instance in the hundreds and hundreds and hundreds of encounters I have had with COVID patients where I couldn't get to a patient, or a patient couldn't get to me when there was a need for that, frankly. So, I mean, the warden might answer otherwise on call buttons and stuff, but honestly I didn't -- I'm not seeing that as an issue in the provision of care.

Those rooms, too, those rooms have their own toilets. They have their own running water and stuff like that. So there is -- it's not like people are being deprived. Even in the quarantine zones, the doors are open. We ask the people, please, we don't want people sick. You're in a room so that it's safe for you. One of our big challenges is, you know, constantly needing to ask the ladies -- the day room is closed. Please don't six of you congregate two and three feet apart.

You're going to increase your risk. Please don't go into someone else's room. You need to adhere to the CDC mitigation guidelines. We had asked the plaintiffs' attorneys to endorse that message with us back in December, and they didn't do that. And the ladies don't always adhere with the mitigation strategies. And so we spend a lot of time kind of trying to re-educate and re-request and manage that. And it's part of the correctional environment. It's one of the reasons that, you know, the attack rates are higher in congregate settings than when you have the capacity to simply say, I was exposed to COVID; I'm going to stay in my house and be in my bedroom with bath and have somebody bring me food and kind of hang out.

We have provided to the ladies -- they get their JPays, they get their televisions, the ladies who haven't had televisions. When we have extra televisions, we bring extra televisions. They're given -- we have book carts. We've put in the -- they like puzzles and coloring books for activities, and we bring those to people so they don't have to be bored, because they're sitting there for two weeks. We understand. Nobody should like that. But we're trying to do all those things to address the physical, psychological, emotional aspects of COVID quarantine and isolation.

THE COURT: All right. Does the defendant have anything else you would like to bring up?

MR. SCHNETZLER: Nothing further from the defendants,

Your Honor.

THE COURT: All right. I'll ask the plaintiffs, is there any issue that you would like for me to bring up that I haven't?

MR. HOWARD: No, Your Honor. I do have some -- a few general responses to what we've heard from the defendants --

THE COURT: Okay.

MR. HOWARD: -- and Dr. Targonski. But if you --

THE COURT: Okay. Go ahead.

MR. HOWARD: Your Honor, a couple of things. One is that we do get quarterly reports, and we appreciate those, and they're obligated to provide them. But even the quarterly reports don't have underlying data in many instances. And so we're not in a position to, you know, just confirm as a result of documentation we've been provided the accuracy of representations that are made without citation and without a specific supporting document, as is reflected in the status report.

Secondly, if the quarterly report -- the most recent one was for a period concluding in December, which we don't question. But there was a separate outbreak after that of COVID-19 at the prison before February 8th when the defendants filed their status report, then there is no reason and no excuse for it not to be mentioned in the status report.

Third, the problem that is reflected in the colloquy

here is -- is fundamental to the situation that we're in. We sent emails to defense counsel indicating that women were expressing concern about the lack of information that they had about the safety and efficacy of the vaccination. Then we hear that all this information has been provided, and as a result 77 percent of the population has been vaccinated. Well, why would it be so difficult for them to just tell us that in response?

We cannot possibly get this case resolved in the way contemplated by the settlement agreement if we can't have better communication between the parties than we have now. Every inquiry or email that we send them seems to be regarded as an attack of some sort, when all we're asking for is information. We have no reason to complain to you about a lack of information if we're getting it. And we also can make more progress towards that date on which a year of full compliance begins to run if we're collaborating and cooperating with one another, rather than reacting to every single communication as if it's some adversarial attack.

And so I really think there needs to be some behavior modification here. And frankly, I mean, all we have to go on is what we hear from our clients. And if they disagree -- and when we tell them in an informal communication, this is what we're hearing; can you please let us know whether it's true or false or somewhere in between, and they don't respond at all, I don't know how we make progress under those circumstances.

Lastly, I guess that I would point out, as we stated in our status report -- and this is at the bottom of page 2 carrying over to page 3 -- by email on February 2nd, 2021, Dr. Venters requested from FCCW the following information: One, the current COVID-19 response plan or documents that are utilized by the health and security services for the facility COVID-19 response; and two, updated data on COVID-19 cases from the start of the pandemic to now, including the number of cases identified, the current number of people in quarantine or medical isolation, the total number of COVID-19-related hospitalizations, and the total number of people offered and who have received COVID-19 vaccination.

Plaintiffs do not know whether defendants have provided that information to Dr. Venters. We still don't know. We assume that they provided it, because we haven't seen any follow-up emails from him to them asking for it again. But if they did, we didn't get it. So that's an example of a situation in which they could provide us the information at the same time as they provide it to the monitor, and we would know, rather than having to complain about it in a status report and then be told --

THE COURT: Okay. Let's stop right there. Can the defendant answer that, why the information couldn't be provided right at the same time?

MR. SCHNETZLER: And Your Honor, I mentioned this

earlier. It was information that we had previously provided to the plaintiffs. All the information that I provided to Dr. Venters had been previously provided. So if they would like me to resend that information, I can do that. Dr. Venters requested it. I provided it to him. So I don't know what else I'm supposed to do in that situation. And I have not heard anything -- any additional -- as Mr. Howard said, there has been no follow-up or additional request for other information from Dr. Venters. So if I have neglected to provide anything to Dr. Venters, or that we had not previously provided to plaintiffs' counsel, we would copy him. We copied plaintiffs' counsel on multiple communications to Dr. Venters about the COVID plan. So it did not seem to make sense to me to send thousands of pages of documents to Ms. Howard and Ms. Ellis that had already been previously transmitted to them.

THE COURT: Well, when they ask for something you've already sent, at least you could maybe say, Look, I've already sent this to you, look in your file, rather than just not responding.

MR. SCHNETZLER: And I'm not -- I mean, Mr. Howard didn't -- or Ms. Ellis didn't request copies of any of the materials that Dr. Venters requested. There was no followup from them.

THE COURT: All right. Mr. Howard, would you like to proceed before I interrupted you?

MR. HOWARD: Your Honor, that's fine. I guess the last thing I would say is that because Dr. Venters is here and with us today, if he has any comments on the basis of the information that he has been provided to date regarding COVID-19 protocols or any other observations that he would like to make, we would certainly welcome those.

THE COURT: Well, I'm glad to see Dr. Venters here, and I will let him comment. But I hope we can take this opportunity for everyone to commit to doing what needs to be done to bring this matter to a head and bring the center into full compliance.

Dr. Venters, any observation you would like to make at this time? You're not required to. I mean, I'm not asking you to speculate, if you don't have -- haven't reached any conclusions or anything, but is there anything you would like to say?

DR. VENTERS: No, Your Honor. I'm happy to be part of the team working toward the conclusion that you've referenced. I have an email ready to go that I was just waiting until the hearing today to make sure nothing changed it about my visit, which is next week, which will go over three days. I do have just a couple of additional document requests that I'll include in that email, and I propose the activities that I'll undertake for the visit next week. And so I'm eager to use that time to both identify numerators of what's

happening, and also denominators of what we think should happen, and what we can all agree should be metrics that we can measure on an ongoing basis month over month. So I'm eager to get moving on this case.

THE COURT: All right. Thank you. Anyone else have any observation they would like to make at this time?

Well, if not, I appreciate all of you getting together with us, and the reports you've filed. And I think we'll look forward to the next few months, and hopefully we'll be able to see a lot of progress.

So we're going to adjourn at this time. Thank you very much.

(Proceedings concluded, 10:58 a.m.)

C E R T I F I C A T E

I, Lisa M. Blair, RMR/CRR, Official Court Reporter for the United States District Court for the Western District of Virginia, appointed pursuant to the provisions of Title 28, United States Code, Section 753, do hereby certify that the foregoing is a correct transcript of the proceedings reported by me using the stenotype reporting method in conjunction with computer-aided transcription, and that same is a true and correct transcript to the best of my ability and understanding.

I further certify that the transcript fees and format comply with those prescribed by the Court and the Judicial Conference of the United States.

/s/ Lisa M. Blair Date: March 9, 2021